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ABSTRACT

The Minnesota Senior Study, the first statewide survey of the elderly in nearly 20 years, was based on a telephone survey with a statewide sample of 1,500 non-institutionalized Minnesotans age 60 and older. Substantial numbers of Minnesotans age 60-plus were found to have low social contacts. Five percent, or about 33,000 older Minnesotans, fell into the "isolation" pattern. They saw both family and friends no more than monthly. All together, 30 percent, or about 200,000 older persons in Minnesota were either isolated or had low contact with friends and family. "Isolated" elderly, compared to older persons with more active social networks, were far more likely to lack a confidant, to have no one to help in an emergency, and to have no long-term caregiver available. The fact that large numbers of older Minnesotans had limited contact with both family and peers provides a strong case for continued, if not increased, funding for programs that facilitate social involvement with others, such as congregate dining, senior centers, and special programs for seniors through churches and other organizations. (Author/LLL)

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ISOLATED ELDERLY*

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Abstract

Findings from the Minnesota Senior Study indicate that substantial numbers of Minnesotans age 60+ have low social contacts. Five percent, or about 33,000 older Minnesotans, fall into the "isolation" pattern--that is, they see both family and friends no more than monthly. All together, 30 percent, or about 200,000 older persons in Minnesota, are either isolated or have low contact with friends and family. "Isolated" elderly, compared to older persons with more active social networks, are far more likely to lack a confidant, to have no one to help in an emergency, and to have no long-term caregiver available. The fact that large numbers of older Minnesotans have limited contact with both family and peers provides a strong case for continued, if not increased, funding for programs that facilitate social involvement with others--such as congregate dining, senior centers, and special programs for seniors through churches and other organizations.

ISOLATED ELDERLY

In old age, there tends to be a net loss in social roles--through widowhood, retirement, and the increasing frailty and death of age-peers. For similar reasons, especially because of the physical effects of aging, there may be an increased need for caregiving. There is, therefore, a dual reason for concern about social isolation among older persons: that older people, compared to adults at younger ages, have a greater risk both of being socially isolated and of needing social support.

How prevalent is social isolation among the elderly--i.e., minimal contact or involvement with others? What are the consequences of social isolation? Should a person be considered isolated if he/she is married but has virtually no contact with anyone other than the spouse? Is a person isolated if he/she lives alone, rarely sees anyone, but likes being alone and is content with life?

How Often are Older Persons Socially Isolated? A number of studies have shown that most older people maintain ties with both family and friends and that the great majority are not socially isolated. However, "social isolation" is defined and measured in different ways; and it is, therefore, not surprising that estimates of social isolation among the elderly vary. One study, for example, found that only 2 percent of elderly had no contact with relatives outside the home, 1 percent had no close friends, and 2 percent had no contact with neighbors (see Chappell, cited in Keith, 1986). Another study, found that 19 percent of elderly did not have many good friends (see Campbell et al., cited in Keith, 1986). Keith (1986) reported that people who are both aged and non-married may be doubly vulnerable to isolation; she found that about a third of non-married respondents in her sample never associated with friends or neighbors.

Scheidt (1984), in a study of 1000 residents of 18 small Kansas towns, found that 19 percent of his sample were "fully engaged;" 46 percent were "partially engaged;" 17 percent were "disengaged;" and 8 percent were "frail." The "partially engaged" respondents visited friends about twice a month and were involved in community activities. The "disengaged" people were healthy, both physically and mentally, but had a low degree of social activity. The "frail" respondents had lower mental and physical health than other groups, were mostly women, and had low morale. The frail were the most needy but also had the lowest amount of social contact.

Social Isolation and Health. One of the reasons for concern with social isolation is the documented impact on mental health. Mueller (1980), in a comprehensive review of the literature on social networks and mental health, noted that a common theme among social factors associated with mental disorders is the absence of adequate social ties and/or disruptions in the social network. Mueller cited a number of studies suggesting that social support reduces the impact of stress. For example, he cited research which found that unemployed men who have emotional support from their wives experience fewer symptoms than men in nonsupportive marriages (Gore, 1973, cited in Mueller, 1980). He also provided evidence that the absence of a confiding relationship is critical in the development of depression (Brown, 1975; Lowenthal and Haven, 1968; Roy, 1978, cited in Mueller, 1980). Research in social gerontology also has found strong correlations between social ties and psychological well-being (see Keith, 1986).

In addition to the impact on mental health, there is substantial evidence that social isolation has negative consequences for physical health. House and his co-authors (1988: 541) argue that an accumulation of empirical evidence shows that the lack of social relationships

> constitutes a major risk factor for health--rivaling the effect of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity, and physical activity. Indeed, the theory and evidence on social relationships and health increasingly approximate that available at the time of the U.S. Surgeon General's 1964 report on smoking and health, with similar implications for future research and public policy.

There is physiological data to suggest that the presence of or contact with another person can modulate cardiovascular activity (House et al., 1988). In fact, social isolation is associated with elevated mortality rates (Keith, 1986).

Social Networks. Social networks have been studied in terms of functions (what kinds of help, etc. are provided) and structures (the characteristics of networks). Functions offered by social support networks include socialization, help with everyday tasks, and help in time of great need (see Cantor, in Mancini and Bliezner, 1989). Wan (1982) points to two measurable features of network structures: reachability (access to helpers) and range (the size of the help network).

Litwak (1985) has theorized that primary groups differ in structure and, therefore, in function. The essential feature of kinship ties, for example, is long-term commitment. Kin maintain their commitments across geographical distance and

time separations. In contrast, ties with neighbors and friends are voluntary and lack "institutional pressures for permanence" (Litwak and Szelenyi, 1969:469). The implication of Litwak's perspective is that a lack of social support could have different consequences--depending on the type of social support that is missing.

At least to some degree, however, people may substitute one type of relationship for another. Kivett and Learner (1980), in a study of rural elderly, reported that childless adults compensate by developing other ties. Even so, their findings generally support Litwak's thesis. They found that not having a child did *not* diminish the possibility of having someone in whom one could confide but childless elderly in rural areas were more likely than elderly parents to be without transportation. In Litwak's terms, confiding is a type of support consistent with the structure of friendship, because friends are likely to be age peers and to be chosen because of similar values. Conversely, adult children have long-term relationships with their elderly parents and are important for the type of help that requires a long-term commitment. We would expect, then, that children would be more likely than neighbors and friends to be consistent helpers with services such as transportation.

It appears that different types of relationships contribute to psychological and physical well-being. A study by Berkman and Syme, in Alameda, California, looked at four types of social ties: marriage, contacts with family and friends, church membership, and other formal/informal group affiliations. This nine-year prospective study found that *each* of these types of relationships had a separate impact on mortality (cited in House et al., 1988).

The Minnesota Senior Study

This paper is based on analysis of data from the Minnesota Senior Study, which was conducted by Wilder Research Center and was the first statewide survey of the elderly in nearly 20 years. The study was based on a telephone survey with a representative state wide sample of 1,500 non-institutionalized Minnesotans age 60 and older. Probability sampling techniques, with stratification by region, and a weighting procedure were used so that the sample represents persons age 60 or older living in all regions throughout Minnesota. The survey data were collected in 1988.

Since only one person age 60 or older was interviewed in each household, persons who live alone or who are the only person 60 or older in their households are overrepresented in the sample. To adjust for this over-representation, responses

were weighted by the number of persons 60 years old or older in the home. The weighted sample, 2,214, is equal to the number of persons 60 and older living in the 1,500 households.

Eligible respondents were selected through random digit dialing to Minnesota telephone exchanges. When more than one respondent age 60 or older resided in the household, the eligible respondent was randomly selected by using the most recent birthday method of respondent selection (Salmon and Nichols, 1983). Based on the total of eligible cases, the response rate was 68 percent. A comparison of our sample with Census data and 1990 population estimates suggests that, overall, the study sample is an adequate representation of non-institutionalized Minnesota seniors 60 years and older in households with telephones.

The questionnaire covered a broad range of topics: demographic characteristics (age, income, education, etc.); housing; transportation; health and daily functioning; social supports; employment; and participation in volunteer work. Indicators of social supports included questions on frequency of seeing children, frequency of seeing friends and other relatives, frequency of talking on the telephone with children, frequency of talking on the telephone with friends and other relatives, and whether or not the respondent would have various kinds of social support, if needed: help in an emergency, help if he/she were sick or disabled, and someone to confide in.

A number of efforts were pursued to make the sample as representative and as reliable as possible. For example, telephone numbers were called 10 times if there was no answer, before a number was excluded. Potential respondents who initially refused to participate were all called again and given another chance to be part of the sample. When some answers were unclear, these respondents were called back. Special arrangements were made to gather information on respondents who might have difficulty with telephone interviews (for example, informants were used when respondents were too impaired to answer questions themselves and translators were made available for those who were not fluent in English). The questionnaire was pre-tested and underwent many revisions; and the interviewers were given extensive training and supervision.

In a second phase of the Minnesota Senior Study, 1,500 additional interviews were conducted so that separate analyses could be conducted on all the regions of the state. These additional data, when appropriately weighted, increased the size of the sample for a portion of our analyses. Specifically, we have used the expanded sample (N = 3,000) to create a profile of the "oldest-old" in Minnesota--those 85+.

For further description of the Minnesota Senior Study, see Fischer et al., 1989; 1990.

Limitations of the Minnesota Senior Study. Despite these efforts to assure the quality of the data, the Minnesota Senior Study has a number of limitations. First, with "older Minnesotans" defined as 60 and over, the sample tends to be weighted toward the young-old. Second, the exclusion of the institutionalized elderly means that the most frail and the most needy are systematically left out of the sample. (This is especially of concern because Minnesota has a relatively high rate of institutionalization for the elderly.) Third, because the study was based on telephone interviews, we could not reach elderly without telephones (about 3% of elderly in Minnesota have no telephone); it is also likely that we have undercounted elderly who live in boarding houses or inner city hotels where there is only one phone per building or per hallway. Finally, because of time constraints and the need to ask a broad range of questions, the coverage of each topic is quite limited and there are few details on most issues.

The Sociability Scale

In order to examine the extent to which the elderly respondents in our study are socially involved or socially isolated, we constructed a "Sociability Scale" which combines two variables--(1) seeing children and (2) seeing friends and other relatives. (For convenience, throughout this paper, we will refer to the latter question as seeing "friends" or "peers.") For each variable, we have divided the responses into three groups, according to the amount of face-to-face contact: *frequent* (several times a week or more); *occasional* (weekly or several times a month); and *rare* (monthly or less). Combining these variables, we have five patterns of contact with both children and peers:

Highly Involved:	frequent interaction with both children and friends
Child-Oriented:	frequent interaction with children, occasional or rare interaction with friends
Friend-Oriented:	frequent interaction with friends, occasional or rare interaction with children
Low Contact:	rare contact with children, occasional contact with friends or rare contact with friends, occasional contact with children or

	occasional contact with children and occasional contact with friends
Isolated:	rare contact with both children and friends

The Sociability Scale gives us a quick overview of social involvement. This scale allows us to identify individuals who have substantially less social contact than others in the sample. It also allows us to distinguish between elderly whose social lives are oriented around their family (i.e., their children) versus those who tend to be oriented toward social contact with peers (i.e., friends and other relatives).

Limitations of the Sociability Scale. The Sociability Scale, however, has a number of important limitations, which need to be kept in mind when interpreting our findings. First, the questions on which this scale is based are summary measures and give no details about interpersonal relationships. For example, a person who says "hello" to her next door neighbor every day when she picks up the mail but has no other contact might say that she has "daily" contact with "friends and other relatives," as would a person who spends all day, everyday, socializing with a large group of friends. A second difficulty is that the question about seeing "friends and other relatives" does *not* specify *who* those friends/relatives are. Thus, for example, we have no way of knowing whether a respondent's social network is large or small or what types of relationships are included (neighbors? siblings? close and/or casual friends?). Similarly, we have little information about their children--such as whether they have daughters or sons, the gender of their local children, whether they have grandchildren (or local grandchildren), the ages of their children, which children they see, etc. A third limitation is that the scale is based only on questions about "seeing" children or friends--not on telephone contact. A fourth problem is that we have very limited measures of the emotional consequences of social isolation. (There were only two questions on loneliness and on depression: "Is loneliness a problem for you? and "Is depression a problem for you?") Finally, because of the nature of this sample, our estimate of isolated elderly is likely to be an underestimate. It is very likely that people who are very isolated will be underrepresented in a telephone survey.

Sociability and Social Isolation

The Frequency of Social Isolation. **Table 1** shows the distribution of the sample on the Sociability Scale. From this table, we can see that the largest category is the

"friend-oriented" pattern. In fact, the elderly are almost three times more likely to have social lives oriented around peers than around children. Of course, to some degree, this distinction is artificial. There is no limit, at least theoretically, to the number of people one might designate as a friend. Conversely, some elderly have no children or no children living nearby; and, in any case, a person has a defined number of children. Even so, this distribution does suggest the salience of peer-socializing in the social worlds of older people. Even if the stereotype about minimal contact with children were true (which it is not), this would still not mean that the elderly were "isolated"--as long as they regularly see their peers.

Five percent of the sample fall into the "isolated" pattern. These are people who see both children or peers no more than monthly. Whether this is a large or small number is a matter of interpretation. Clearly, the socially isolated represent a small minority. Even so, 5 percent of the non-institutionalized elderly population constitute sizable numbers--about 33,000 elderly in Minnesota appear to be socially isolated. (This figure is an approximate projection to the population of 669,253 older Minnesotans living in the community--i.e., not in institutions--in 1988, when the survey was conducted.) Moreover, when we also include those with "low contact," the proportion who lack frequent contact with either children or peers is sizable. The categories of "low contact" and "isolated," taken together, comprise 30 percent of the elderly--the second largest group. This would suggest that about 200,000 older Minnesotans have rather limited social involvement.

How do we interpret these numbers? Specifically, what circumstances are subsumed in the "low contact" category? It might be a person who has no children or no children living nearby and who visits a friend or more distant relative once a week or less. Or it might be a person who has almost no friends to get together with and who has a weekly visit from a child. Or it might be a person who has two visits a week: a visit from a child and visit from a friend. Of course, the Sociability Scale includes *only* face-to-face contact; a much smaller percent of our sample (fewer than 12%) lack frequent telephone contact with children and friends. Even so, other research has suggested that telephone contact is less intimate than face-to-face contact. Communciation by telephone, since it lacks both eye-contact and continuity, tends to inhibit confidances (see Gerstel and Gross, 1984). We do not know, with data just from the Sociability Scale, to what extent people choose to have little contact with others and do not wish to have more active social lives. We also cannot tell, just from our numbers, what the quality of these face-to-face interactions

are like. Nonetheless, by any standards, it seems that large numbers of elderly have rather constricted social worlds.

Variability in Social Contact. In **Table 1**, the Sociability Scale has been cross-tabulated with three demographic variables--marital status, age and region. This table suggests that there is some variation in social interaction--by marital status, age, and region.

Non-married elderly appear to be somewhat more likely to have friend-oriented social contacts, whereas married elderly are a little more likely to be involved with children. The old-old (75+) appear somewhat more likely to be isolated than the young-old (60-74): the old-old are less often "highly involved" and are more likely to be in the "low contact" or "isolated" categories.

As **Table 1** suggests, however, the clearest differences are by region. In Minnesota, the population in the Twin Cities area is largely urban/suburban, while the rest of the state ("Greater Minnesota") is comprised mostly of small towns and rural areas. As this table shows, the elderly in the Twin Cities appear a little more likely to have social lives oriented around interactions with their children (the "child-oriented" category). This probably can be explained by the fact that the elderly in the Twin Cities are more likely than Greater Minnesota elderly to have children living nearby: 76 percent of Twin Cities elderly, compared to 59 percent of Greater Minnesota elderly, have children living within a 30-minute drive. Overall, however, the elderly in the Metro area are less likely to be in the "highly involved" or "friend-oriented" groups and are more likely to be found in the "low contact" and "isolated" patterns.

Elderly in the sample who have frequent interactions with peers are in either the "high involvement" or "friend-oriented" categories (depending on whether they see both friends and children or only friends frequently). These categories combined, therefore, indicate levels of interaction with peers. When we take these two groups together (from **Table 1**), we find that three fifths of the elderly in Greater Minnesota, compared to about half of elderly in the Metro Area, have frequent face-to-face contact with peers (i.e., seeing friends or other relatives several times a week or more often).

There is no significant correlation between the Sociability Scale and other demographic variables--i.e., gender, income, or education.

Consequences of Lacking Social Ties. **Table 2** suggests some of the implications of social isolation. This table shows the percent of elderly who lack a confidant, who say they would not have help in an emergency, and who would *not* have a caregiver if they become sick or disabled, by the Sociability Scale. The sample has been divided into married and non-married. Presumably, a person who lacks both a spouse and other social ties is more isolated than a married person who rarely sees anyone other than a spouse. Indeed, overall, those who are both non-married and "isolated" from other social contacts are, by far, the most likely to lack a confidant, a helper in an emergency, or a caregiver if sick or disabled.

Table 2 is also suggestive of the differences in the functions provided by family versus friends. Elderly whose social involvement is primarily focused on their children (the "child-oriented" category) are more likely than most other elderly to lack what peers provide--that is, a confidant. Conversely, we see that non-married elderly whose social involvement is primarily with peers (the "friend-oriented" category) tend to lack what family provides--that is, long-term care if they become sick.

When we look at the relationship between social isolation and mental health, our data are sparse and our findings, overall, show no pattern. Our questionnaire included two items on mental health: "Is loneliness a problem for you?" and "Is depression a problem for you?" We have tested the relationship of these two variables with the Sociability Scale for the sample as a whole and for the non-married respondents. There is no significant relationship between the Sociability Scale and loneliness. For the whole sample, the socially isolated are more likely to say that depression is a problem; but the relationship disappears in the non-married sub-sample. We had anticipated that social isolation would have more negative consequences on the non-married; but this expectation is *not* supported by our data.

Our data include a number of variables on health: self-rated health; change in health; failure to see a doctor; the recent experience of serious illness by self or spouse; and difficulties with ADLs (activities of daily living) and IADLs (instrumental activities of daily living). *None* of these variables is significantly related to the Sociability Scale. There is, thus, no evidence from our data that physical illness is either a cause or consequence of social isolation.

Aging and Social Support. **Table 3** presents a profile of social supports by age, comparing the young-old (60-74), the old-old (75-84) and the oldest-old (85+). This table is based on a specially constructed sample, from the second phase of the

Minnesota Senior Study. The expanded sample (N = 3,000) was used for this analysis so that there would be sufficient numbers of oldest-old. In the original, statewide sample, there are about 90 respondents age 85+; in the expanded sample there are about 260.

As **Table 3** suggests, there is a tendency for social support deficits to increase with advancing age. The oldest-old, for example, are more likely than the young-old to have no living children, to lack regular contact with friends, to have no one to care for them if they become sick or disabled, and to have a problem with loneliness. It is difficult, of course, to disentangle the separate effects of aging and cohort. Even so, it is clear that the very old in Minnesota tend to be significantly more vulnerable to social isolation than other age groups. The last item--on being a non-driver--may seem to be different from the other indicators of social support. We would argue, however, that access to transportation has clear implications for access to social support. People who do not drive are limited to public transportation (in a state where public transportation services are often not readily available); and/or they have to rely on others for rides (which creates dependency); and/or they are confined to forms of support and services accessible in their neighborhoods. All of these are significant limitations. The fact that almost 70 percent of the oldest-old are neither drivers nor have spouses who drive suggests that this population is at risk to be isolated.

Summary and Implications

Our analysis suggests that there are substantial numbers of elderly who lack frequent contact with family and friends. These "isolated" elderly often have deficits in their social support networks. We found, for example, that two-fifths of the non-married isolated elderly lack important types of support systems--a confidant and help with long-term care.

Are special programs needed for increasing social opportunities for older persons and for outreach to the most isolated elderly? The fact that about 200,000 older Minnesotans have limited contact with both family and friends provides a strong case for continued, if not increased, funding for programs that facilitate social involvement with others--such as congregate dining, senior centers, and special programs for seniors through churches and other organizations. Furthermore, the substantial numbers of "isolated" elderly (over 30,000 in Minnesota) suggest that better outreach efforts are needed. For example, campaigns, through television,

churches, and other community programs, could encourage neighbors to identify and seek out elderly who appear to be isolated and at risk.

In examining the social supports of the older people, we need to pay careful attention to how the population of "elderly" is defined. In our sample as a whole, which is comprised of non-institutionalized Minnesotans age 60+, the young-old predominate. But conclusions based on this type of sample can be misleading. As our study reveals, the old-old and the oldest-old have far greater needs for social support services than the young-old.

We also need to be aware, however, that social isolation, by itself, is not necessarily a problem. In our sample, the socially isolated appear to be neither lonelier nor sicker than other elderly. Moreover, even among our categories of "isolated" elderly, the majority indicate that they have a supportive social network. Almost three-fifths of the non-married, "isolated" elderly say they have someone to confide in and someone to help with long-term care; four-fifths say they would have someone who could help in an emergency.

It is likely that many people who appear to be isolated may not want help, offered either by neighbors or formal social service providers. Some people are "loners" who prefer to have infrequent contact with others (see Rosow, 1961). If we are to develop a more adequate understanding of the consequences and policy implications of social isolation, we need a way to distinguish between those isolated by preference versus circumstance.

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Table 1. The Sociability Scale by Marital Status, Age, and Region.*

	Sociability Scale**					
	Highly Involved	Child Oriented	Friend Oriented	Low Contact	Isolated	N***
Total Sample	20%	13%	36%	26%	5%	2,198
Marital Status						
Married	20%	14%	33%	29%	4%	1,504
Non-married	20%	10%	43%	20%	6%	694
Age						
60-74	23%	14%	35%	25%	4%	1,528
75+	14%	12%	38%	29%	8%	614
Region						
Twin Cities	17%	15%	32%	31%	6%	937
Greater Minnesota	22%	11%	39%	23%	4%	1,261

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* The Chi Square statistic was used to test for a relationship between the Sociability Scale and each characteristic. Percentages are reported where results of the test indicated a relationship (i.e., $p < .01$).

** "Highly Involved" refers to frequent interaction with both children and peers. ""Child-Oriented" means frequent interaction with children and occasional or rare interaction with peers. "Friend-Oriented" means frequent interaction with friends and occasional or rare interaction with children. "Low Contact" indicates one of three patterns: rare contact with children and occasional contact with peers, rare contact with peers and occasional contact with children, or occasional contact with children and occasional contact with peers. "Isolated" is defined as rare contact with both children and peers.

*** The sample is weighted by number of people in the household.

Table 2. Percent of the Married and Unmarried Elderly Who Lack Various Kinds of Social Support: a Confidant, Help in an Emergency, and a Caregiver, by the Sociability Scale.*

	Married Elderly				
	Highly Involved	Child Oriented	Friend Oriented	Low Contact	Isolated
Percent Lacking:					
A Confidant	8%	13%	8%	17%	20%
Emergency Help	0%	0%	1%	3%	15%
A Caregiver	3%	8%	8%	7%	29%

	Unmarried Elderly				
	Highly Involved	Child Oriented	Friend Oriented	Low Contact	Isolated
Percent Lacking:					
Confidant	5%	17%	11%	12%	43%
Emergency Help	0%	0%	4%	7%	19%
Caregiver	16%	19%	33%	24%	42%

* The Chi Square statistic was used to test for a relationship between the Sociability Scale and these types of social support. Percentages are reported where results of the test indicated a relationship (i.e., $p < .01$).

Table 3. Social Supports for the Young-Old (60-74), the Old-Old (75-84) and the Oldest-Old (85+).*

	60-74	75-84	85+
Percent with no living children	9%	17%	22%
Percent with no local children	31%	43%	42%
Percent who rarely see children	23%	30%	29%
Percent who rarely see friends	11%	14%	20%
Percent with no caregiver available	12%	20%	25%
Percent saying loneliness is a problem	13%	18%	26%
Percent who neither drive a car nor have a spouse who drives	8%	30%	68%

* The Chi Square statistic was used to test for a relationship between age and these indicators of social support. Percentages are reported where results of the test indicated a relationship (i.e., $p < .01$).